DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155124	B. WIN			08/30/2	011
		Ш			ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
NAME OF F	PROVIDER OR SUPPLIER	L.			MAIN ST		
VERMILL	LION CONVALESCE	ENT CENTER			DN, IN47842		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r the Investigation of	F0	000	Submission of this plan of		
	Complaint IN000	-			correction does not constitue admission or agreement by		
	Complaint IN000	094925-Substantiated,			provider of the truth of facts alleged or correction set for		
	federal/state deficiencies related to the allegations are cited at F323.				the statement of deficience		
					plan of correction is prepare	ed and	
					submitted because of		
	Survey detect A	ugust 20 & 20 2011			requirement under state an		
	Survey dates: August 29 & 30, 2011. Facility number: 000052				federal law. Please accept		
					plan of correction as our creation allegation of compliance.	earbre	
	Provider number: 155124						
	AIM number: 10	00290340					
	Timi namoti. T	00230310					
	Survey team: Jo	yce Hofmann, RN					
	Census bed type:	:					
	SNF/NF: 100						
	Total: 100						
	10141. 100						
	Census payor typ	oe:					
	Medicare: 6						
	Medicaid: 75						
	Other: 19						
	Total: 100						
	10001. 100						
	Sample: 3						
	-						
	These deficiencie	es also reflect state					
		accordance with 410 IAC					
	16.2.	accordance with 410 II to					
	10.4.						
	Quality review c	ompleted on September					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIO	GNATURE		TITLE		(X6) DATE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LERI11

Facility ID:

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED	
		155124	A. BUILE B. WING			08/30/2	
	PROVIDER OR SUPPLIER			1705 S	DDRESS, CITY, STATE, ZIP CODE MAIN ST N, IN47842		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T '	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG	2, 2011 by Bev F			ing	<u> </u>		DALL
F0323 SS=D	The facility must e environment rema hazards as is poss receives adequate devices to prevent Based on record rev facility fair assistive d for a resid history to falls/accid residents residents residents residents. Resident	nsure that the resident ins as free of accident sible; and each resident supervision and assistance accidents. interview and riew, the filed to have levices in place ent with a fall prevent further lents for 1 of 3 reviewed for ample of 3. #B]	F03	23	1. Resident #B suffered no at harm.2. Residents, who are a risk for falls, have the potentibe affected. See below for corrective action.3. The polic and procedure for Fall Preverwas reviewed and no change were indicated at this time. A nursing staff were inserviced the Fall Prevention Policy and Procedure on 9/2/11. (See Attachment A) The Director Nursing or her designee will all new resident admissions a re-admissions within 24-48 hof admission. Residents with history of falls prior to admiss will be assessed for risk factor which may require the use of alarmed device. Chart audits be completed with every new admission. (See Attachment Results of the chart audits wireviewed in the Quarterly Quassurance meeting.5. The atcorrective actions will be completed by 9/14/11	at al to cy ntion es All on d audit and ours a sion ors a will r B)4.	09/14/2011
	clinical re						
	reviewed	on 08/30/11 at					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124		(X2) MULTIP. A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE COMPL 08/30/2	LETED
	PROVIDER OR SUPPLIER		STR 170	05 S	MAIN ST DN, IN47842		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	9:30 a.m.,	and indicated					
	the resident was						
	admitted t	to the facility					
	originally	on 06/21/10					
	and re-adi	nitted on					
	07/19/11 a	and most recent					
	re-admiss						
	08/08/11 with diagnoses						
	which inc	luded, but were					
	not limited	d to, fall, end					
	stage chro	onic obstructive					
	pulmonar	y disease,					
	coronary a	arteriosclerosis,					
	cardiovas	cular disease,					
	diabetes, S	Stage III					
	chronic ki	dney disease,					
	azotemia,	chronic					
	ischemic l	neart disease,					
	coronary a	artery disease,					
	,	ongestive heart					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	00	COMPI		
		155124	B. WIN			08/30/2	011
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE MAIN ST	•	
VERMILI	LION CONVALESCI	ENT CENTER		1	DN, IN47842		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	failure, ca	rdiomegaly,					
	supraventricular						
	tachycard	ia, neuropathy,					
	Clostridiu	m difficile					
	[c-diff], u	rinary tract					
	infection	[uti], long term					
	urinary catheter,						
	dissociativ	ve and					
	somatofor	m disorder,					
	insomnia,	anxiety,					
	weakness	, loss of					
	ambulatio	n, and					
	dementia.	The resident's					
	closed clin	nical record					
	indicated	she was a do					
	not resusc	citate resident					
	and did no	ot want CPR					
	performed	l as a					
	life-saving	g measure.					

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155124		(X2) MULT A. BUILDII B. WING		NSTRUCTION 00	(X3) DATE S COMPL 08/30/2	ETED
	PROVIDER OR SUPPLIER		1	705 S I	DDRESS, CITY, STATE, ZIP CODE MAIN ST N, IN47842		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Hospital r	ecords with					
	last admit date of						
	08/04/11,	indicated the					
	resident w	as brought to					
	the emerg	ency room					
	from hom	e with a history					
	of tachyca						
	falling. T	he resident had					
	been unde	er the care of					
	Hospice a	nd when trying					
	to stand at	t home with					
	assistance	became very					
	weak and	was eased to					
	the floor.	The resident					
	cannot wa	lk, her legs are					
	very weak	and she					
	complaine	ed of pain in					
	the tailbor	ne. At the					
	hospital sl	ne was found					
	to have ta	chycardia of					

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			NSTRUCTION 00		(X3) DATE COMPL	
		155124	A. BUI B. WIN	LDING IG			08/30/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STAT	ΓE, ZIP CODE		
VERMILL	LION CONVALESCE	ENT CENTER		1	MAIN ST N, IN47842			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX		AN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCEI	D TO THE APPROPRIAT CIENCY)	E	DATE
	136 and a	lso a history of						
	chronic ob	ostructive						
	pulmonar	y disease. The						
	resident w	as also found						
	during hos	spitalization to						
	have an u	rinary tract						
	infection a	and c-diff. The						
	resident w	as discharged						
	back to the	e nursing home						
	on 08/08/1	11 with final						
	diagnoses	of Clostridium						
	difficile ga	astroenteritis						
	with sever	re diarrhea,						
	tachycard	ia, chronic						
	urinary tra	act infection						
	with long-	-term urinary						
	catheteriza	ation, loss of						
	ambulatio	n, coronary						
	artery dise	ease, history of						
	chronic ob	ostructive						
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID:	LERI11	Facility I	D: 000052	If continuation sh	neet Pa	ge 6 of 34

PRINTED: 09/23/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		155124	A. BUI B. WIN	LDING IG		08/30/2	2011
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
VERMILI	ION CONVALESCI	ENT CENTER		1	MAIN ST DN, IN47842		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	v	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	COMPLETION DATE
	pulmonar	y disease, and					
	cardiomeg	galy.					
	The hospi	tal records					
	indicated	the resident					
	had been in failing health						
	for the past several						
	years, was	s basically					
	non-ambu	latory, and was					
	total care	at home since					
	she could	not feed					
	herself. H	Ier caregiver					
	could no l	onger provide					
	her with the	he care she					
	needed so	she was					
	placed in	the nursing					
	home. Th	e records					
	indicated	she complained					
	of chronic	headache,					
	x-ray show	wed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 0/2011	
	PROVIDER OR SUPPLIER		1705 S	ADDRESS, CITY, STATE, ZIP CO MAIN ST DN, IN47842	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR. (EACH CORRECTIVE ACTION SECONDS-REFERENCED TO THE ADEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	cardiomeg	galy and				
	chronic in	terstitial				
	changes, t	the resident had				
	severe tac	hycardia,				
	diarrhea, v	weakness and				
	inability to	o walk. Lungs				
	had decrea	ased breath				
	sounds, de	eep basilar				
	rales, and	some fecal				
	impaction					
	The reside	ent's closed				
	clinical re	cord indicated				
	a facility's	s Fall Risk				
	Assessme	nt, dated				
	08/08/11,	which				
	indicated	a history of				
	falls, use	of assistive				
	devices, c	onfusion at				
	times, wea	akness,				
	!					ı

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 08/30/2	LETED	
	PROVIDER OR SUPPLIER		 	STREET A	MAIN ST DN, IN47842	-1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	unsteady §	gait, poor					
	vision/blii	nd (glasses),					
	non compliance issues						
	(refuses n	eb treatments,					
	refuses to	eat at times),					
	use of nar						
	hypnotics,						
	anti-hyper	tensives,					
	hypoglyce	emics,					
	diuretics,	and					
	benzodiaz	epines which					
	all made t	he resident a					
	fall risk.						
		ent's initial care					
	* 1	d 08/08/11,					
	indicated	a problem of					
	"The resid	lent is @ [at]					
	risk for fa	lls R/T [related					
	to] weakn	ess, end stage					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMP		
		155124	A. BUI B. WIN	LDING NG		08/30/2	2011
NAME OF I	PROVIDER OR SUPPLIER	<u>-</u>			DDRESS, CITY, STATE, ZIP CODE MAIN ST		
VERMILI	LION CONVALESCI	ENT CENTER		1	N, IN47842		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	COPD [cl	nronic					
	obstructive pulmonary						
	disease] c	[with] sob					
	[shortness	s of breath]					
	upon mini	imal exertion."					
	The interventions						
	included, assess &						
	monitor g	ait, call light					
	within rea	ch, provide					
	adequate 1	lighting, assure					
	proper no	n-skid					
	footwear,	keep walkway					
	clutter fre	e, physical					
	therapy ev	valuation, and					
	occupation	nal evaluation.					
	Another c	are plan, dated					
	08/08/11,	with problem					
	of "The r	esident has					
	multiple r	isk factors for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPLI		
		155124	A. BUII B. WIN	G		08/30/20	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE MAIN ST		
VERMILL	ION CONVALESCE	ENT CENTER			DN, IN47842		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		as: Dementia,					
	hx [history	y] of falls,					
	weakness,	use of					
	assistive d	levices,					
	confusion	@ x's [times],					
	weakness,	unsteady gait,					
	poor vision (Rx						
	[prescription] glasses						
	worn), no	n-compliance					
	issues, use	e of narcotics,					
	use of hyp	onotics, SOB,					
	use of ant	ihypertensives,					
	use of hyp	oglycemics,					
	use of diu	retics, use of					
	benzodiaz	epines, related:					
	anxiety, h	x of falls, end					
	stage COI	PD, IDDM					
	HTN, AS	•					
	Cardiome	galy,					
	Azotemia						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		INSTRUCTION 00	(X3) DATE COMPL		
		155124	B. WIN			08/30/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE MAIN ST		
VERMILL	ION CONVALESCE	ENT CENTER		1	DN, IN47842		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	Kidney D	isease Stage					
	III, obesity	y, neuropathy,					
	tachycardi	ia, Loss of					
	ambulatio	n."					
	Intervention	ons included to					
	provide ac	lequate					
	lighting, e	nsure					
	pathways	are clutter free,					
	resident to	utilize					
	footwear v	with non-skid					
	soles, mor	nitor the					
	resident fr	requently when					
	the call lig	ght is not					
	available ((i.e. dining					
	room, acti	vities, etc.),					
	complete	fall risk					
	assessmen	nt upon					
		, and at least					
	quarterly t						
	444110117						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·	(X2) MI	JLTIPLE CON	NSTRUCTION		(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155124	A. BUII		00		08/30/2	
			B. WIN		DDRESS, CITY, STAT	E. ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	MAIN ST	_,		
VERMILL	ION CONVALESCE	ENT CENTER		CLINTO	N, IN47842			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF DD FFTY (EACH CORRECTIVE ACTIO				
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCEI	TO THE APPROPRIAT CIENCY)	E	COMPLETION DATE
	monitor vi	ital signs as						
	indicated,	notify						
	physician	and						
	responsibi	llity if a fall						
	occurs, im	•						
	11 1	te interventions						
	to reduce	risk for falls:						
	(list interv	rentions and						
	date initia	ted), physical						
	therapy ev	aluation						
	8/8/11, oc	cupational						
	therapy ev	aluation						
	8/8/11, 1/2	2 head of bed						
	safety rail	s up times 2,						
	8/8/11, up	in wheelchair						
	as tolerate	ed 8/12/11,						
	Physical T	Therapy 5 times						
	weekly tir	nes 6 weeks,						
	Treatment	to include						
	therapeuti	c exercises,						
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID:	L LERI11	Facility II	D: 000052	If continuation sh	neet Pa	ge 13 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124			(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 1/2011
	PROVIDER OR SUPPLIER		1705 S	ADDRESS, CITY, STATE, ZIP C MAIN ST DN, IN47842	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	therapeuti	c activities,				
	NWR [ne	uro muscular				
	re-educati	on], and gait				
	training, 8	8/8/11,				
	Occupation	onal Therapy 5				
	x weekly	x 30 days.				
	treatment	may include				
	activities	of daily living,				
	therapeuti	c-exercises,				
	thera-activ	vity.				
	 Resident #	#B's Social				
	Service P	rogress Notes,				
	dated 08/1	10/11 at 10				
	a.m., indic	cated the				
	resident h	ad been asking				
	to go hom	e today. The				
	resident to	old Social				
	Service sh	ne didn't have				
	anyone to	care for her				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		155124	B. WIN	LDING NG		08/30/2	011
NAME OF I	PROVIDER OR SUPPLIER		·		NDDRESS, CITY, STATE, ZIP CODE MAIN ST	•	
VERMILI	ION CONVALESCI	ENT CENTER		1	N, IN47842		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	DATE
	and that a	ll her children					
	wanted he	er to stay at the					
		ome and none					
	of her chi	ldren were able					
	to take car	re of her, also					
	her husba	nd was so deaf					
	he could r	not hear her					
	when she	needed help.					
	The reside	ent stated she					
	wanted to	go home and					
	asked if the	ne doctor					
	would let	her go home.					
	The Socia	l Service					
	Director is	ndicated she					
	would let	the doctor					
	know as s	oon as he came					
	in that day	y .					
	Social Ser	vice Progress					
	Notes, dat	ted 08/08/11 at					
	•						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124				LDING	NSTRUCTION 00	COM	TE SURVEY IPLETED 1/2011
	PROVIDER OR SUPPLIER		P. WIII	1705 S	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	LION CONVALESCE			l	N, IN47842		1 33
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	2 p.m., inc	dicated the					
	doctor car	ne to the					
	facility an	d the above					
	information	on was given to					
	him. The	doctor stated					
	the resider	nt could not go					
	home unti	l she had					
	someone t	to care for her					
	at all time	s. The doctor					
	stated she	is dying, has					
	severe end	d stage COPD,					
	and she ca	annot care for					
	herself, sh	e was not able					
	to do anyt	hing, she's					
	dying, her	family can't					
	care for he	er, and she					
	needed to	be somewhere					
	for 24 hou	ir care. The					
	doctor exp	plained the					
	family trie	ed to care for					
							-

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124			LDING	NSTRUCTION 00	C	DATE SURVEY OMPLETED //30/2011	
	PROVIDER OR SUPPLIER		D. WIN	1705 S	DDRESS, CITY, STATE, ZIP CO MAIN ST N, IN47842	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	her and tri	ed to walk her					
	at home w	hen she went					
	down due	to severe					
	weakness.	The Social					
	Service D	irector					
	explained	the resident					
	does not a	ttempt to do					
	anything f	for herself, the					
	facility ev	en has to move					
	her arms.	The doctor					
	explained	before the					
	resident co	ould go home					
	they woul	d have to come					
	up with a	plan for 24					
	hour care.	The doctor					
	indicated	the resident					
	had been o	on and off of					
	Hospice s	everal times,					
	she's non-	compliant, and					
	non-accep	ting/unrealistic					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		155124	B. WIN	LDING NG		08/30/2	011
NAME OF I	PROVIDER OR SUPPLIER		·		DDRESS, CITY, STATE, ZIP CODE MAIN ST	•	
VERMILI	LION CONVALESCI	ENT CENTER		1	NN, IN47842		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	DATE
	about her	diagnoses, and					
	not doing	well. The					
	Social Ser	vice Director					
	talked to t	the resident					
	about why	she could not					
	go home a	at this time and					
	the resider	nt voiced					
	understan	ding, but					
	wanted to	talk to her son					
	the next ti	me he came up					
	about livii	ng with him					
	once she g	got a little					
	stronger.						
	Resident 1	Progress Notes,					
	dated 08/1	12/11, indicated					
	the reside	nt continued to					
	eat and dr	ink poorly.					
		indicated the					
	resident g	ags when they					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I	MULTIPLE CO			(X3) DATE S COMPL	
AND LAN	OI CORRECTION	155124		JILDING	00		08/30/2	
			B. WI		DDRESS, CITY, STAT	TE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				MAIN ST	,		
VERMILL	LION CONVALESCE	ENT CENTER		CLINTO	N, IN47842			
(X4) ID		TATEMENT OF DEFICIENCIES		ID		AN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	E	COMPLETION DATE
	try to feed	her food. The						
	notes indi	cated the						
	resident w	as total care						
		oing nothing						
		f except sitting						
	in her recl							
	notes indi	cated the						
	resident w	as on 5 liter of						
	oxygen pe	er nasal						
	cannula.							
	Resident I	Progress Notes,						
	dated 08/1	12/11 at 3:30						
	p.m., indic	cated the nurse						
	was called	d to the						
	resident's	room as the						
	resident w	as exhibiting a						
	decrease i	n level of						
	conscious	ness, oxygen						
	sats were	82%, blood						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	LERI11	Facility I	D: 000052	If continuation sh	neet Par	ge 19 of 34

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124		A. BUI	LDING	NSTRUCTION 00	C	DATE SURVEY COMPLETED /30/2011
		D. WIN	STREET A 1705 S	MAIN ST	DE	
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
pressure v	vas 90/62,					
pulse 120	, respirations					
20, and te	mperature was					
98.9. The	resident's eyes					
opened to	verbal stimuli,					
but the res	sident did not					
respond v	erbally. A					
nebulizer	treatment was					
given and	the oxygen					
sats went	up to 91%.					
The docto	r was paged.					
At 4 p.m.,	the doctor					
returned the	he page and					
gave new	orders for					
Clysis inf	usion into the					
fatty tissu	e/injection of					
fluid into	the body other					
that orally	of LR					
[Lactated	Ringers] with					
5% Dextro	ose at 84					
	provider or supplier summary s	OF CORRECTION IDENTIFICATION NUMBER:	pressure was 90/62, pulse 120, respirations 20, and temperature was 98.9. The resident's eyes opened to verbal stimuli, but the resident did not respond verbally. A nebulizer treatment was given and the oxygen sats went up to 91%. The doctor was paged. At 4 p.m., the doctor returned the page and gave new orders for Clysis infusion into the fatty tissue/injection of fluid into the body other that orally] of LR [Lactated Ringers] with	DENTIFICATION NUMBER: 155124 REQUIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRESSURE WAS 90/62, pulse 120, respirations 20, and temperature was 98.9. The resident's eyes opened to verbal stimuli, but the resident did not respond verbally. A nebulizer treatment was given and the oxygen sats went up to 91%. The doctor was paged. At 4 p.m., the doctor returned the page and gave new orders for Clysis infusion into the fatty tissue/injection of fluid into the body other that orally] of LR [Lactated Ringers] with	DENOTIFICATION NUMBER: 4.5 BUILDING 8. WING PROVIDER OR SUPPLIER LION CONVALESCENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Pressure was 90/62, pulse 120, respirations 20, and temperature was 98.9. The resident's eyes opened to verbal stimuli, but the resident did not respond verbally. A nebulizer treatment was given and the oxygen sats went up to 91%. The doctor was paged. At 4 p.m., the doctor returned the page and gave new orders for Clysis infusion into the fatty tissue/injection of fluid into the body other that orally] of LR [Lactated Ringers] with	OF CORRECTION DENTIFICATION NUMBER: 155124 A BUILDING 100 B WING 155124 STREET ADDRESS, CITY, STATE, ZIP CODE 1705 S MAIN ST CLINTON, IN47842 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) pressure was 90/62, pulse 120, respirations 20, and temperature was 98.9. The resident's eyes opened to verbal stimuli, but the resident did not respond verbally. A nebulizer treatment was given and the oxygen sats went up to 91%. The doctor was paged. At 4 p.m., the doctor returned the page and gave new orders for Clysis infusion into the fatty tissue/injection of fluid into the body other that orally] of LR [Lactated Ringers] with

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124			(X2) MULTIPLE CC A. BUILDING B. WING	00	lì í	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		1705 S	ADDRESS, CITY, STATE, ZIP CO MAIN ST DN, IN47842	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	cc/hr., cle	ar liquid diet				
	for 24 hou	ırs, comfort				
	foods only	y, hold insulin,				
	if blood si	ugar more than				
	200, give	5 units of				
	Novolog.					
	The Resid	lent Progress				
	Notes, dat	ted 08/12/11 at				
	4:30 p.m.,	, indicated the				
	infusion v	vas started in				
	the left ab	domen without				
	difficulty.					
	Resident 1	Progress Notes,				
	dated 08/1	12/11 at 9:45				
	p.m., indi	cated the				
	resident w	as alert to				
	verbal stir	nuli, but still				
	not respor	nding verbally;				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMP 08/30/2	LETED	
	PROVIDER OR SUPPLIER			1705 S	ADDRESS, CITY, STATE, ZIP CODE MAIN ST DN, IN47842		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	IV continu	ues to infuse					
	without di	ifficulty;					
	resident in	ndependent					
	with bed 1	nobility at this					
	time; refu	sed all 4 p.m.					
	and 8 p.m	. medications;					
	and refuse	ed supper.					
	Resident I	Progress Notes,					
		12/11 at 10					
	p.m., indi	cated the					
	-	as found on					
	the floor v	with head at the					
	foot of be	d and appears					
	_	tempted to get					
	up by self	1					
	lethargic,						
		Vital signs					
	_	blood pressure					
		se 54, temp					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155124		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPI 08/30/2	LETED	
	PROVIDER OR SUPPLIER			1705 S	MAIN ST DN, IN47842		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	99.0, resp	irations 22, and					
	oxygen sa	ts of 94%.					
	The notes	indicated the					
	physician	was notified					
	and orders	s received to					
	place the	resident back in					
	bed and k	eep					
	comfortab	ole. The notes					
	indicated	the POA was					
	notified.						
	Additiona	l Nursing					
	Progress 1	Notes, dated					
	08/12/11 a	at 10 p.m.,					
	indicated	the resident					
	was found	l on the floor					
	on her rigi	ht side, eyes					
	open, and	non-verbal. A					
	contusion	was noted					
	under the	resident's right					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		P. W.	STREET A 1705 S	ADDRESS, CITY, STATE, ZIP CODE MAIN ST DN, IN47842		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	side of ch	in measuring					
	2.0 x 2.5 c	cm. and purple					
	in color.	Two small					
	drops of b	lood noted on					
	floor unde	er chin.					
	Husband a	and physician					
	notified of resident's						
	condition.	The physician					
	stated the	resident was					
	hospice an	nd dying, place					
	her back i	n bed and					
	make her	comfortable.					
	The nurse	informed the					
	physician	she was not					
	hospice, b	out orders					
	remained	the same. The					
	notes indi	cated cyanosis					
	was noted						
	Resident I	Progress Notes,					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155124		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/30/2011
		100124	B. WINGSTREET	ADDRESS, CITY, STATE, ZIP CODE	00/30/2011
	PROVIDER OR SUPPLIER		1705 8	S MAIN ST	
	LION CONVALESCE			ON, IN47842	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		12/11 at 11:25			
	p.m., indic	cated the nurse			
	walked in	to the resident's			
	room to ta	ke vitals and			
	found the	resident			
	without re	espirations or			
	pulse and	asked skilled			
	nurse to v	erify with her.			
	Further no	otes indicated			
	the doctor	was paged			
	and orders	s were given to			
	release the	•			
	 The facili	ty's Incident			
		th incident date			
	_				
		1 at 11 p.m.,			
		the resident			
	was found	l on the floor			
	beside her	bed at			
	approxima	ately 10 p.m.,			
	11	J 1 ,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 0/2011	
	PROVIDER OR SUPPLIER		1705 S	ADDRESS, CITY, STATE, ZIP (MAIN ST DN, IN47842	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	lying on h	er right side				
	with her a	rm underneath				
	her head a	and her eyes				
	open. The	e report				
	indicated,	"It should be				
	noted that	this was the				
	resident's	third stay at the				
	facility an	d she had not				
	had any p	revious falls.				
	This resid	ent had been at				
	home on h	nospice at				
	various in	tervals and				
	until her h	ospitalization				
	on 8/4/11,	she was				
	receiving	hospice				
	services a	t home.				
	During th	is stay, she had				
	been evalu	uated by PT,				
	OT, ST, a	nd RT. The				
	resident d	id utilize her				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155124	A. BUILDING B. WING		08/30/2011	
NAME OF B			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER			1	MAIN ST	
	LION CONVALESCE			ļ	DN, IN47842	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	call light v	when she				
	needed as	sistance and				
	had given	no indication				
	of attempt	ted transfer or				
	ambulatio	n without staff				
	assistance	. Further,				
	therapy ha	ad given no				
	additional					
	recommer	ndations in				
	regard to	fall prevention				
	intervention	ons."				
	The repor	t indicated the				
	resident re	eceived a 2.0				
	cm. x 2.5	cm. contusion				
	under righ	nt side of chin				
	with a sma	all amount of				
	bleeding.	The resident				
	was imme	ediately				
		The RN called				
	the physic					
	- r - J J	-				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		155124	B. WIN	LDING IG		08/30/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u>-</u>		1	DDRESS, CITY, STATE, ZIP CODE MAIN ST		
VERMILI	LION CONVALESCI	ENT CENTER			N, IN47842		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	DATE
	sending th	ne resident to					
	the hospit	al for					
	evaluation	n; however, the					
	physician	gave an order					
	to assist the	ne resident					
	back into	bed and keep					
	her comfortable. The						
	husband was called and						
	notified of	f the fall with					
	contusion	. Neuro checks					
	were initia	ated and were					
	within no	rmal limits.					
	Interventi	ons of placing					
	the reside:	nt in a low bed					
	and the ap	plication of an					
	alarm wer	·e					
	recommen	nded and were					
	implemen	ted after the					
	fall. Staff	returned to					
	again asse	ess the status of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/30/2011	
N	DROLUBER OF SUMMISSION		B. WING STREET.	ADDRESS, CITY, STATE, ZIP CODE	33/30/2011
	PROVIDER OR SUPPLIER LION CONVALESCE		I	MAIN ST	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	ON, IN47842	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
	the reside	nt at 11 p.m.,			
	and the re	sident was			
	found with	h no pulse and			
	no respira	tions. The			
	resident w	as a no code,			
	thus heroi	c measures			
	were not i	nitiated. The			
	physician	and family			
	were notif	fied. The			
	physician	verbally stated			
	that the re	sident's cause			
	of death w	vas			
	Multi-Sys	tems Failure.			
	Interview	with RN #1 on			
	08/29/11 a	at 3:22 p.m.,			
	indicated	the resident			
	had never	attempted to			
	get out of	bed, was not in			
	a low bed	, but a hospice			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 0/2011	
	PROVIDER OR SUPPLIER		p. wiiv	STREET A 1705 S	ADDRESS, CITY, STATE, ZIP CODI MAIN ST DN, IN47842		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	bed with t	he head of the					
	bed up and	d was end					
	stage COI	PD. RN #1					
	indicated	after they got					
	the resider	nt back in bed					
	staff got a	mat to put at					
	bedside and put an alarm						
	on her. R	N #1 indicated					
	she told th	ne physician a					
	couple of	times she was					
	not hospic	e this time she					
	was admit	ted to the					
	facility. F	RN #1 indicated					
	her last ca	ll to the					
	physician	she told him					
	again she	was not					
	hospice, b	out the					
	physician	said make her					
	comfortab	ole. RN #1					
	indicated	she was not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LERI11

Facility ID:

000052

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S		
		155124	A. BUII B. WIN			08/30/2	
NAME OF F	PROVIDER OR SUPPLIER		'	1	ADDRESS, CITY, STATE, ZIP CODE	•	
VERMILL	ION CONVALESCE	ENT CENTER		1	MAIN ST DN, IN47842		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
	aware of a	any previous					
	falls.	-					
	Interview	with CNA #3					
	on 08/29/2	11 at 5:45 p.m.,					
	indicated	when they					
	went in to	put the					
	resident ba	ack to bed, she					
	was chang	ging colors,					
	dark color	ed - purple					
	face. CNA	A #3 indicated					
	there was	no mat on the					
	floor and	she did not					
	recall an a	alarm. CNA #3					
	indicated	the head of bed					
	was up an	d the resident's					
	breathing	was					
	different,1	ike someone					
	getting rea	ady to die; the					
	resident's	eyes were open					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124		A. BUI	LDING	00	COMPI 08/30/2	LETED	
NAMEOU	DDOWNED OF GUIDN TER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	MAIN ST		
VERMILLION CONVALESCENT CENTER				L	DN, IN47842		(7/5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	with a star	re look; and the					
	resident d	id not seem to					
	be in any	pain, looked					
	like she w	as resting well.					
		tal a					
	Interview	with the					
	physician	on 08/29/11 at					
	3:50 p.m.,	indicated the					
	resident h	ad been going					
	down hill	since 3 p.m.					
	and had b	een on hospice					
	and was e	nd stage in the					
	disease pr	ocess. The					
	1 2	indicated he					
		e resident had					
	a stroke w	hich was					
	probably t	the cause of					
		possibly the					
	fall. The						
	indicated	the resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LERI11

Facility ID:

000052

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED /2011
		1705 S	MAIN ST	CODE	
(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION :	SHOULD BE	(X5) COMPLETION DATE
probably	did not get				
enough ox	xygen to her				
brain.					
Interview	with the				
Director o	of Nursing				
[DON] on 08/30/11 at					
2:05 p.m.,	, indicated				
Resident #	#B did not				
move, sta	ff had to move				
her arms,	and she didn't				
think she	needed an				
alarm, ma	t, or anything				
to prevent	falls as she				
had never	attempted to				
get up on	her own				
before.					
This feder	ral tag is related				
to Compla	aint				
	probably enough or brain. Interview Director of [DON] or 2:05 p.m., Resident a move, stather arms, think she alarm, may to prevent had never get up on before.	DENTIFICATION NUMBER: 155124 PROVIDER OR SUPPLIER JON CONVALESCENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) probably did not get enough oxygen to her brain. Interview with the Director of Nursing [DON] on 08/30/11 at 2:05 p.m., indicated Resident #B did not move, staff had to move her arms, and she didn't think she needed an alarm, mat, or anything to prevent falls as she had never attempted to get up on her own	DENTIFICATION NUMBER: 155124 ROVIDER OR SUPPLIER LION CONVALESCENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Probably did not get enough oxygen to her brain. Interview with the Director of Nursing [DON] on 08/30/11 at 2:05 p.m., indicated Resident #B did not move, staff had to move her arms, and she didn't think she needed an alarm, mat, or anything to prevent falls as she had never attempted to get up on her own before. This federal tag is related	DENTIFICATION NUMBER: 155124 ROYUDER OR SUPPLIER JON CONVALESCENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Probably did not get enough oxygen to her brain. Interview with the Director of Nursing [DON] on 08/30/11 at 2:05 p.m., indicated Resident #B did not move, staff had to move her arms, and she didn't think she needed an alarm, mat, or anything to prevent falls as she had never attempted to get up on her own before. This federal tag is related	PROVIDER OR SUPPLIER JON CONVALESCENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION) Probably did not get enough oxygen to her brain. Interview with the Director of Nursing [DON] on 08/30/11 at 2:05 p.m., indicated Resident #B did not move, staff had to move her arms, and she didn't think she needed an alarm, mat, or anything to prevent falls as she had never attempted to get up on her own before. This federal tag is related

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CC		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155124	B. WING		08/30/2011
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
VEDMILI	LION CONVALESCE	ENT CENTED		MAIN ST DN, IN47842	
				JN, IN47042	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
	IN000949	25.			
	3.1-45(a)(1)			
	3.1-45(a)(3.1-45(a)((2)			
	3.1 - 43(a)((4)			